# REMARKS ON THE

# CONTINUED FEVERS OF LOUISIANA.*

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*Mr. President and Gentlemen*—At the meeting held in April, 1885, I had the honor of calling the attention of this Society to the "Long continued fevers of Louisiana that resist quinine."

In the nine years that have elapsed since the reading of that paper my opportunities for observation have greatly increased, and I feel that I have gathered sufficient evidence to permit me to formulate a few conclusions pointing to the real nature of these fevers. In the paper referred to I insisted upon the distinctive clinical type of our continued fevers, and emphasized its differential characteristics from malarial fevers and from typhoid. I also confirmed the careful observation of Dr. John Guiteras who had studied this fever in Key West, and had described it as an independent morbid entity in a paper published March 10, 1885, in the *Therapeutic Gazette*, under the title "Continued fever, or so-called typhoid fever of the tropics, or continued thermic fever." I believed with him then that it was neither malarial or typhoid nor a hybrid combination of both, but the result of some form of exhaustion of the heat regulating apparatus.

It is now unnecessary to reproduce the clinical picture of the fever in question—we all know it, though we may

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call it by different names. I simply desire to supplement my paper of 1885 by expressing the opinion that the type of fever in question is not a new or independent morbid entity, but an atypical typhoid fever. This opinion is based upon the following conclusions derived from personal observation and experience and by clinical records which substantiate the facts:

1. The course of the long continued fevers of Louisiana is not in the least altered or influenced by the cinchona alkaloids; ergo, it is not a malarial fever from the therapeutic standpoint.

2. That this fever occurs at all seasons of the year, though it is more prevalent during the summer months; ergo, it is not a "thermic" fever pure and simple.

3. That cases of the fever occur in groups (and probably in districts), several members of a household being attacked simultaneously or in rapid succession; ergo, infection from a common source.

4. That while the true classical and grave typhoid type of fever is exceptional and comparatively rare, it nevertheless exists in our midst in persons who are born in this city and who have never lived elsewhere; ergo, typical typhoid fever exists as an endemic in New Orleans.

5. That in the comparatively rare cases of typical typhoid fever all the essential characteristics of the typhoid state are present, viz.: long continued fever, varying from four to six weeks, with typical chart; adynamic state, stupor, low muttering delirium, diarrhea, intestinal hemorrhages, perforation of the bowels and fatal peritonitis.

6. That in many other (less rare) cases the febrile movement, though long continued, presents few of the adynamic or ataxic characteristics of the typhoid state; the mental state is good, but diarrhea and intestinal hemorrhage are nevertheless present.

7. That in the majority of the cases the chief and ap-

parently only characteristic of the fever is its persistence; its long duration and rebelliousness to antiperiodic or other medication. The only point of contact between this and the preceding types lies solely in the continued thermic movement.

8. In infected houses, where several cases are under treatment, it is not very rare to observe a fever of a most *typical* and grave typhoid type running through its course by the side of a benign *atypical* fever in which there are no adynamic symptoms, no diarrheas, no hemorrhages, nothing, in fact, but a simple and uncomplicated thermic movement.

I would now also state, as a pure matter of personal belief without a sufficient basis of statistical facts outside of general personal observation, that it is my impression that:

1. The true malarial type of fever—the strictly intermittent—is gradually disappearing from the city limits, and is now almost restricted in its prevalence to the swampy portion of our suburbs.

2. That the continued type of fever is gradually gaining the ascendency and the true typhoid type is becoming yearly more frequent.

3. That this gradual transition from the intermittent to the plain remittent continued, and, finally, to the continued typhoid type of fevers, is a phenomenon that has been observed elsewhere, where the original conditions of nature gradually suffered profound alterations from the presence of a progressively increasing human population; that malarial fevers are the products of the unredeemed, uncultivated swampy lands while the typhoid type is a product of human aggregation which usually follows in the wake of increased means of communication and other conditions inherent especially to metropolitan life.

4. That this transition in our fever type is being effected gradually without any perceptible change in our water, milk or food supply, or in our sewerage or drainage sys

tem, and that the only conditions that have changed have been the notable increase in the facilities for communication between this and other large northern and western metropolitan centres where the typhoid type of fever has long dominated and whence it could be readily imported.

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Finally, a word as to treatment:

The vast majority of our cases are benign in their tendency and require only symptomatic and hygienic treatment and careful nursing. The chief therapeutic indication is usually to control an excessive or hyperpyretic movement. In sthenic cases the anti-thermic remedies, especially phenacetin and anti-febrin in small doses and in combination with some alcoholic will meet the indication. My rule has been never to administer an anti-thermic dose (2-3 grs.) unless the temperature rises above 103 deg., and in the latter stages, when the patient is showing signs of exhaustion, never to give the dose until 104 deg.

In the asthenic cases stimulation with proper nourishment and the cold bath constitute my chief reliance. The method of Brand is far superior to all forms of anti-thermic medication, but it is difficult to apply in the homes of the poor, who are without help and unable to pay for the services of a competent nurse.

In the asthenic cases in which the ordinary anti-thermics are badly tolerated, and in which for fear of hemorrhages or other causes it is impossible to move the patient to the bath, I believe that the epidermic use of guaiacol by Sciolla's method, and DaCosta's directions, is of service in combating hyperpyrexia. I have here a chart of a typical case which occurred a few months ago in which guaiacol did good service.

As an adjunct of great value in reducing fever and in diminishing the tendency to delirium I always insist upon the use of the ice bag or ice pillow as a head rest.

All the other indications for complicating conditions should be met in the manner described in the classics.